
JANUARY 1939
R.N.
A JOURNAL FOR NURSES

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IN *This* ISSUE

January, 1939 Vol. 2, No. 4

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A JOURNAL R.N. FOR NURSES

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NO "BORN NURSES"

Dear Editor:

It is a relief to us all to know that (in New York State at least) *conscientious* practical nurses are to be acknowledged as respectable workers by the law and receive a license. Perhaps now, those who are decidedly *not* conscientious, but have a flattering manner to both patient and visitor, will no longer be invested with that mystical title "born nurse." That title somehow, in the minds of the gullible public, seems to tower above training schools, head nurses, state board examinations, and hospital diplomas.

This evil about to be righted leaves but one more problem—the effect of a white uniform and cap upon the public! There is a fixed idea that a white dress and starched cap make a nurse...If practical nurses could be uniformed alike according to law, it would help straighten out the problem. Why not some color in direct contrast to the uniforms worn in accredited hospitals where a degree is given?

Adele L. Knapp, R.N.
Rockville Centre, N.Y.

BEST WISHES

Dear Editor:

The greeting card habit is indeed a useful one to the nurse in private duty. Christmas, Valentine's Day, Easter, and birthdays are grand opportunities to wish our ex-patients well. Children especially appreciate them. It is a thoughtful gesture. Don't you agree this is a good way to keep your name in the minds of your former patients and friends?

Rebecca S. Dorsey, R.N.
New Orleans, La.

SEE PAGE 26

Dear Editor:

I wish to congratulate the medical and nursing staff who are responsible for the splendid series of articles, "Quick Facts about Major Diseases." The one on endocrinology (October) was especially good. Would it be possible to have one on syphilis and gonorrhea soon? The latest method of treating these diseases and the protective measures for nurses who are taking care of such cases would be helpful.

Dorothy Meyers, R.N.
San Jose, Calif.

INFORMATION PLEASE

Dear Editor:

At every state convention, the private duty group, the administrative and teaching groups, and almost every other branch of nursing is well represented. Much educational matter and a great deal of time and thought has been spent on their problems. But I have not yet found a space or section devoted to the general duty nurse and her interests. Have you?

What is new in general duty? What does the general duty nurse do with her leisure? What hours does she work? What schedule of work is most satisfactory to her and to the hospital? Does she study—and what? How does the hospital cooperate in helping her to advance? What good does postgraduate work do her? These are only a few of the things we general duty nurses like to know about.

There are many nurses in general duty who would like to advance, but they do not know how to go about getting what they want in education...

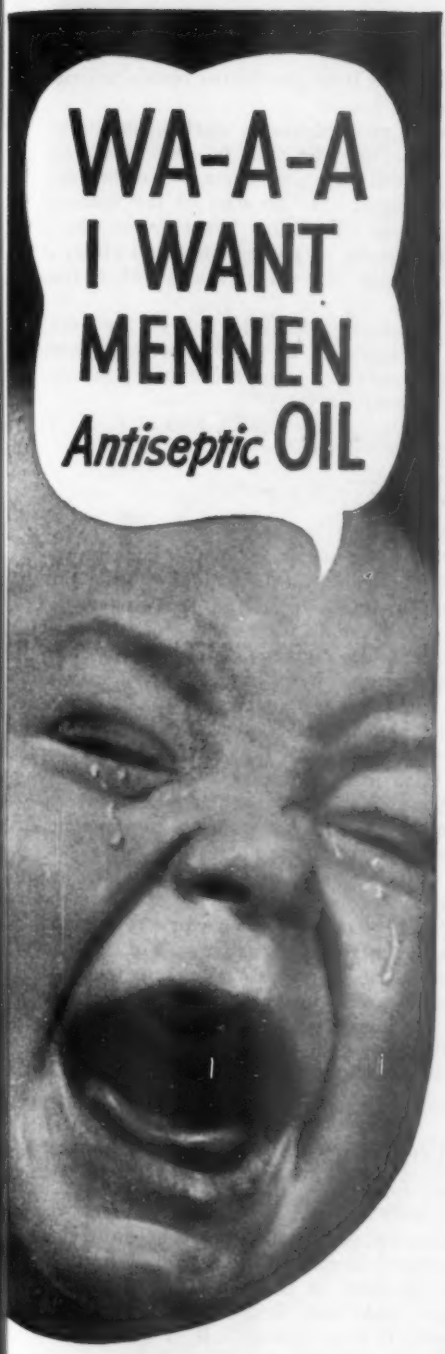
Amber R. Whitaker, R.N.
St. Paul, Minn.

REGISTRY ETHICS

Dear Editor:

I believe that some nursing bureaus warrant investigation by qualified *registrants*. Such investigation might disclose the reasons why the untrained nurse sometimes receives preference instead of a registered nurse. Nursing bureaus were intended to be for the professional nurse, not for the unprofessional worker.

Applying for work one day, I sat next to a young woman apparently not 20 years old. She told me she wanted a position as



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a nurse. I asked the name of her school and if she had her license. She replied that she had not taken a course but had experience. This was her experience: she had been a maternity patient at a hospital and while she was an "up" patient had assisted with the care of other patients!

Anna M. Berle, R.N.
Brooklyn, N.Y.

HELPMEET

Dear Editor:

May I reply to the writer from St. Louis about "Too Many Brides?" I am a married nurse and would like to present my side of the story.

When we were engaged, I knew what my fiancé's income was. I also knew it was too little to support us both. Now, what would you do if you wanted to marry and the man did not make enough money?

Wait?

You probably would not. You'd go ahead with the marriage—and your work.

It is all well and good to say, "I won't marry until my husband is able to support me." But in these days many men with real ability find it impossible to obtain a living wage.

As to married nurses working for luxuries, that may be true in some instances. Before criticizing, however, remember that most people have no idea of the financial obligations of others. What looks like a good amount of money, free and clear, is often spent for many things other than luxuries.

The majority of married nurses are working because it's the only plan that made their marriage possible. Would you condemn them for it?

R.N., Brooklyn, N. Y.

LIVELY INTEREST

Dear Editor:

Now that we have more time to ourselves, can't we as individuals plan a program of intensive study? In doing so we keep our minds alert, and this will help keep us always young.

It may be interior decorating; it may be any of the many subjects that comprise a college education. Anyway, let it be something that you are interested in and eager to learn more about.

You will be surprised at the rejuvenation that will take place after having found a new interest. One nurse I know took up oil painting and has found much satisfaction in her work.

"Plan your work, then work your plan." Plan to study constructively. You will become a more interesting person, your vocabulary will increase, your conversation will no longer be a jumble of words spoken without thought.

Irene B. Mauritz, R.N.
Westwood, Mass.

RICHEST

Dear Editor:

I don't know of any group of nurses who will enjoy your grand magazine more than we nurses in far-off little towns. I am nursing up here in the mother lode country where gold was first discovered in California. It is a country full of historic lore and yet unknown to many Americans.

I haven't always been a small-town nurse; sometimes I wish I had been. Living in a small community brings us so much closer to life. Until a few years ago, most of my

For becalmed *peristaltic waves*

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work was in hospitals in large cities. Age kept creeping up on me and then, suddenly, I found myself in this quaint old town. I feel I have missed much by not discovering it sooner. It hasn't gone modern and is much the same as it was in the days of 1849...

Age isn't a problem any more. I graduated in 1905 and am still nursing and still love it. I realize that the younger nurse must have her day. And why not? I had mine and enjoyed it. Some day the elderly nurse who has worked so long will have her old age provided for. In the meantime she must make the most of the opportunities open to her.

Margaret F. Mott, R.N.
Jackson, Calif.

RINGS OUT

Dear Editor:

I can't understand why nurses on duty, at least a great many of them, wear rings of every description. They aren't sanitary and are certainly not suitable to wear with a uniform.

Bertha E. Howorka, R.N.
Los Angeles, Calif.

WHY NOT?

Dear Editor:

About a year ago, one of my graduate nurses had an opportunity to accept a position in a larger institution at an increase in salary. I attempted to replace her during the 10-day notice period she gave me. I interviewed five superintendents personally and called four more. They were unable to find anyone who would do general duty in a tuberculosis sanatorium, even though I had offered a salary exceeding that paid to general duty nurses in most hospitals.

Why this aversion to tuberculosis nursing? It is the easiest type of nursing as far as physical labor is concerned. On the whole, if one is physically and mentally fit, it is a very satisfying phase of the profession.

As in all nursing, there are certain factors to be considered. The main one is the danger of contact. The posters of the tuberculosis associations, reading: "One case comes from another," apply to nurses as well as to anyone else. But all T.B. is not in institutions. The next time you attend a movie, listen to the coughing public.

Although we have more graduate nurse patients than any other profession represented, only one had previously nursed in a tuberculosis sanatorium. Many, however, were infected by patients who did not know they had the disease themselves and made no effort to protect the nurse. This happens again and again to nurses actively engaged in nursing in general hospitals...

R.N., Jacksonville, Ill.

LIKE OTHERS

Dear Editor:

We all like to air our dislikes and mine is 20-hour duty. I don't think any nurse should be asked to work such long hours and be expected to give her best to the patient. Yet many of us still take 20-hour cases in preference to having no work at all.

Private duty is my choice of nursing. But when will those of us in small towns get a break like the nurses in cities—work eight hours and then go home to live like other people?

Nellie R. Stone, R.N.
Uniontown, Kan.

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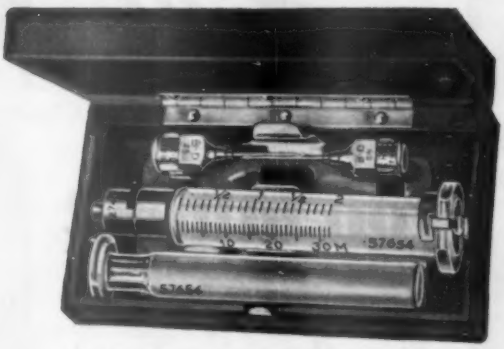

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Do nurses *Talk* too much?

Ewing Galloway

This author says we do, and cites instances to prove her point. What do you think?

BY MARGARET FOSTER, R.N.

• In *The Citadel,* miffed Nurse Sharpe told tales "out of case" about Dr. Manson. Her opinion was a fifty-fifty combination of limited professional knowledge and spite. But her talking nearly cost Dr. Manson his license, creating bitter controversies and suffering.

Perhaps the physician-author named the character with tongue in cheek, knowing that Nurse Sharpes exist outside the pages of fiction. We've all met them; sometimes we ourselves have made the same mistakes. It is a weakness we should guard against, for gossip is vicious, thoughtless, and cruel. Too-garrulous nurses may be responsible for ruined reputations, shattered romances, broken friendships, marital discord, and multiple misunderstandings and hurts.

There are various ways in which we nurses talk too much. Some of us gossip about patients and cases. Others broadcast hospital happenings or take the names of associates in vain. A kindred talking-fault is the tendency to trespass on the doctor's prerogative to diagnose cases and to pass judgment on treatment. Personal affairs, too, are often conversation pieces for convalescing patients.

Sometimes one would think the Florence Nightingale Pledge had never been written, much less accepted by every one of us. That is especially true

of Section 3. It is not at all unusual to hear a nurse bandy about the delirious ravings or irrational convalescent behavior of her patients. Glibly she will expose case histories and bare the secrets of private lives. Yet, in Section 3, she has promised to "hold in confidence all personal matters committed to my keeping, and all family affairs coming to my knowledge in the practice of my profession."

Take Betty G., for example. Betty is a maternity ward nurse in a small, city hospital. A very efficient nurse, too. She is also a heart-of-gold, salt-of-the-earth person, always doing nice things for people. Yet, contrary to Dale Carnegie, she is rapidly becoming a candidate for the lonely hearts club.

When it comes to reporting blessed events and scandal-spiced gossip, Betty out-Winchells Walter himself. She is, in fact, tattling herself socially into wallflower row. The world, his wife, and the in-laws refuse to have their personal affairs, blameless or otherwise, turned into Roman holidays for other ears.

Gossip may be a professional boomerang too. Reprimands, distrust, or even discharge pursue the overheard gossiper. Here is an actual incident which proves the point:

A wealthy country woman had an operation in her local hospital, despite the pleas of friends and relatives that she go to the city. The hospital was small and struggling to win reputation and gain patients from surrounding towns.

Now the patient was the type who put her money into mortgages instead of spending it for silk undies and fashion furbelows. Consequently she was plain but substantial. The hospital rejoiced to have her in their care; her influence was to be desired.

One night the patient awoke to discover her special and the floor nurse having a good laugh together over a strangely familiar piece of apparel. To her complete distress, she recognized the garment as one of her own rayons. Outraged, the patient hauled the erring nurses over verbal coals.

Seeking the cause of his patient's overwrought condition next morning, the physician learned of the incident. Professional Coventry followed for a time for the two nurses. More serious, however, is the effect of the situation on local hospitalization; it has not encouraged the public to use their community hospital facilities. No one enjoys having her tastes ridiculed. Hence, a number of illnesses and operations that might have been handled locally have gone to more distant institutions.

Of course, some patients encourage gossip. It's a form of convalescent entertainment. Franklin once said "Three people can keep a secret, if two of them are dead." Once told, even in strictest confidence, a tale speedily becomes a real-life game of Gossip. In that game, you will recall, the original news is embroidered and distorted almost beyond recognition as it goes from player to player by word of mouth. In the same way, a scrap of gossip related to a patient may snowball into a gigantic scandal.

Stories are given credence because "my nurse told me" or because it came "straight from a nurse at the hospital." As repeated, the tale may vary widely from what you said, but *you* still get the "credit." Appointing yourself monitor-at-large to report human frailties may give you temporary importance. But more significant is the

damage your words may ultimately cause.

Several years ago, the reputation of a popular radio news-commentator was severely jeopardized by a piece of nurse gossip which got out of hand. The newscaster had suffered a breakdown, and word had been given out that he had gone South to recover. On his return to the air, rumor said that his breakdown had been mental rather than physical. . .that he had been "resting" in the state hospital. . .that insanity ran in his family. . .that he had periodic attacks. Fortunately, the man was able to weather the gossip. How did the story start? In the version that became current, it was claimed that a nurse got the information from an attendant at the state hospital. The nurse repeated it to one of her patients as gospel truth—and, as such, it spread like wildfire.

A "tongue-guard" is doubly necessary in dealing with the mentally unbalanced. In their delusions and craftiness, they skilfully fabricate tales around what "the nurse told me." To provide even a grain of substance is to invite trouble for all concerned. Garbled versions of what "the nurse said" cause much of the misunderstanding that exists in regard to the treatment and care of mental patients. Comments to patients, relatives, and friends of the mentally sick are practically certain to be quoted or, more than likely, misquoted.

A hospital superintendent has remarked that "the nurse who doesn't talk shop with her patients is likely to work more days a year." Hospital goings-on, personal affairs, and the private lives of other patients are not the world's best conversational topics for convalescents. Two of the five specials who attended a charming, sophisticated matron during her lengthy convalescence talked themselves out of jobs by choosing such topics.

Wearing your heart on your uniform is another mistake. Actually, it helps neither your professional nor matrimonial cause. A nurse, enamoured of an attending physician, not too subtly inquired about a rival from the patient's home town. The doctor had given her no mortgage on his future. The nurse's hope that the patient would put in a good word for her failed completely. In fact, it worked in reverse; for the reaction caused the odds to go to the rival whom the doctor married the next year.

Talking about doctors, romantically or otherwise, is poor professional etiquette. Some nurses act as self-appointed public relations counselors for certain physicians. Doctors can perform simple problems in arithmetic correctly. If Dr. Smith observes that he frequently loses a case to Dr. Jones when Miss Brown cares for the patient, he puts two and two together. So do other physicians who lose cases in similar fashion. Since doctors must live, soon Dr. Smith, and others whom Miss Brown has talked off cases by her remarks, request the registry to send someone else when in need of a nurse.

It takes very little to plant doubts in the minds of patients or relatives. A seemingly casual comment does it. A well-timed shrug, a lift of the eyebrows, or an indifferent attitude towards the physician speak as loudly as words.

Expressing an opinion about a diagnosis or treatment is dangerous invasion of the doctor's domain. Some per-

[*Continued on page* 44]

See you in *Jail!*

By ROXANN

"He picked up a chair and waved it threateningly . . ."

• To be or not to be—a lawbreaker. That is the question.

And what a question! The chap who was firmly seated on the horns of a dilemma was in a soft spot compared to the conscientious nurse in an emergency not okayed by the nursing jurisprudence books.

My friend Frances was seething with remarks on the subject when she dropped in the other night. She started shedding adjectives, opinions, her hat, and her coat all at the same time.

"Roxy, I've been disillusioned again. But for the last time! I've just thrown my nursing jurisprudence book in the ashcan, and from now on I'm going to reform. I've been a softy long enough, and where did *that* get me?"

"Whoa, there," I said. "What brought this on? Begin at the beginning and tell Aunt Roxy all about it."

"You asked for it," she said viciously. "I'll give you all the gory details, and you can decide whether I was right or wrong.

"It all began back in school with my course in nursing jurisprudence. The instructor was a grand old gal, and the stuff she handed out seemed to be on the up-and-up. But she didn't warn us what happens when theory meets practice, as it frequently does. I know that if you followed her advice you'd never run athwart the arm of justice. Nor would you be on speaking terms with a doctor or a patient. Which is to say that you'd eat semi-annually if you were lucky!"

"Now, Frances, you know that's an exaggeration," I said soothingly, patting her hand.

"Yeah? Then I'll get down to cases, if it's concrete facts you're hankering

for. The first private case I had should have taught me something. It was out in the country—a nice old man who had pneumonia. The doctor drove over every day—22 miles—and checked everything thoroughly. When he was leaving he'd say, 'Now, if anything new comes up, your judgment is as good as mine. You modern nurses know how to use your heads. Give him whatever you think he ought to have.'

"Every night, Roxy, I'd dream of that passage in the text that tells what happens to bad little nurses who practise medicine. You know, that part about ignorance of the law is no excuse! I didn't know which was worse: to refuse to obey the doctor, or to spend my remaining days in jail. Although (fortunately) the patient needed no extra-curricular attention, I was a nervous wreck when the case ended, and my eye was evasive when I finally straggled on home."

"But ---" I started.

"Sh-h-h. Let me get Example No. 2 off my chest. I had a honey of a job in Dr. Mony's office on Park Avenue. His lineup of patients looked like an editorial steal from *Who's Who*. The patient's faith in Dr. Mony was so strong that the laying on of a piece of sterile gauze by The Doctor's Nurse was considered almost a miracle.

"Everything went beautifully until one day the doctor was called out of town. At midnight he phoned me for a general checkup. Then he said in his smoothest tones, 'You know the ropes. Do the treatments and dressings. And give the intramusculars, too . . .'

"Icicles began to form on the edges of my transmitter. 'Doctor,' I interrupted, 'What of the Medical Practice Act?'

" 'Well,' said he, 'what of it?'

" 'There are things I *can* do and things I *can't* do,' I told him acidly.

" 'Here,' said he, 'is something you *can* do. You can answer the telephone and doorbell tomorrow without jeopardizing your precious integrity. And you can look for another job the next day!'

"So, serene in my righteousness, I returned to the Registry. The director murmured something softly about tempering consistency with good judgment, and I went home to wait for a call."

"You *were* on the spot," I agreed. "Reminds me of the story an industrial nurse told the other day. She said that according to the letter of the law she can't give even an aspirin tablet without a doctor's order. (Of course, the patient can hop around to the corner drug store and lunch on a box of them if he wants to.) Anyway, she was sitting alone in her office one morning when a husky foreign workman barged in and said, 'I gotta pain in da bell. You gimme pill, huh?' Well, she took his temperature and pulse and explained that she couldn't give him a pill until the doctor had examined him and prescribed. But Tarzan's head throbbed; he didn't try to understand. He picked up a chair and waved it threateningly. 'You gimme pill, now!' he roared. Just then the doctor arrived and took possession of the chair. That nurse said she was never so glad to see anybody in her life."

"I know exactly how she felt," Frances said fervently. "And I think she would sympathize with me in the case I have just finished—the one that brought on this outburst. It was a maternity case in a home where there were already seven previous blessed events. All seven were well-fed and

unrepressed. And every day one or more of them escaped by inches from murder and sudden death. Guarding the new baby and the mother from their tender antics was only a small part of my unpredictable duties—and I mean 'unpredictable.'

"The family doctor had grown grey sewing up their wounds and setting their bones. After wearing a path from his office to their home, he supervised the setup of a very well-equipped emergency chest. The family soon became skillful in its use, and called the harassed doctor only in the gravest emergencies.

"Things went along nicely my first week. Then, one day, the adults took advantage of the unprecedented calm and went off on long-deferred errands, leaving me in charge of the menagerie. Suddenly a scream from the attic echoed through the house. I bounded up the stairs two at a time and found the whole gang standing admiringly over the still form of Rosemary, aged three.

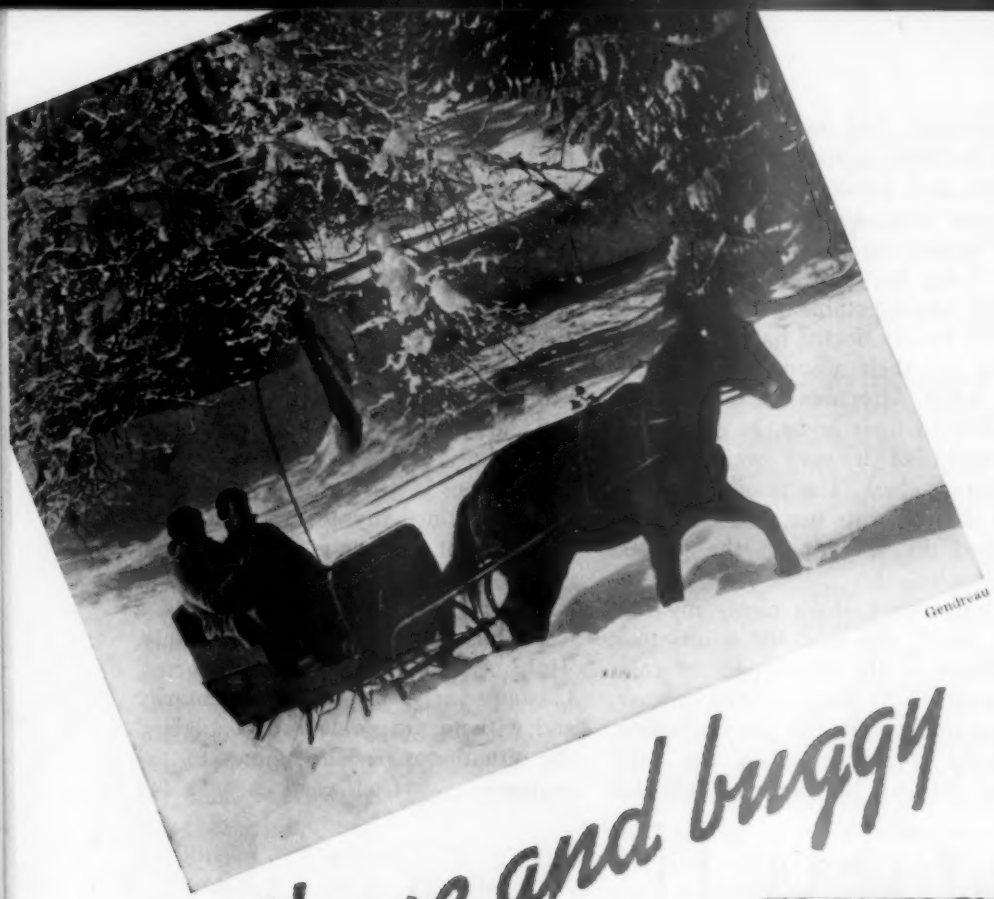
An improvised trapeze had broken, and so had Rosemary's head, from the looks of it.

" 'Bobby,' I said to the oldest, 'Call Dr. Jones immediately. Come on! A little speed, please!'

"The circle of angel faces looked me over calmly. 'No,' said Bobby. 'Mother always does it. Or Father.'

"I restrained myself, and tried reasoning. 'But Mother is ill, and Father isn't home. Besides, we don't know how badly she is hurt.' Nobody uttered a word, but six pair of eyes said plainly, 'Huh! And you think you're a nurse!' I stopped the bleeding momentarily and, with much apprehension, explained the situation over the phone to the doctor. [*Continued on page* 44]

"I bounded up the stairs . . . and found the whole gang standing admiringly over the still form of Rosemary . . ."



Horse and buggy nurse

Did you ever sterilize dressings in a bake oven, or use hot ears of corn for a body pack? Here is the story of nursing "way back when," as told to Myra Carr.

• Fifty years ago things were different. Women then were proud of being the "weaker sex." Laced into tight-fitting corsets, we breathed with difficulty but with beautiful femininity. Restricted by clothes which clung to the torso in all the wrong places, we could not walk far or comfortably. It was considered unladylike *not* to swoon at the sight of blood, and woman's place was definitely in the home.

For a woman to have a profession, in those days—especially nursing—was not quite genteel. Nevertheless, I wanted to be a nurse. Nothing would stop me.

I went into training at 19, nursed 40 years, and saved enough money to retire at 60. Now I'm indulging myself in a luxurious look backward into those none-too-easy but glorious days.

Many a time I've lived again the

scorchy smell of dressings baking sterile in the kitchen range, the late-at-night scrunch of sleigh runners on frosty white snow, the tired ache of interminable typhoid spongings. I remember, too, the trio of starched, beruffled petticoats we wore, and the time I lost one while giving chloroform to a patient who became unexpectedly cyanotic and pulseless.

I can still see the picture I must have made, earnest and pompadoured, stepping primly out across the barnlot for fresh eggs to tempt my patient's appetite. Or maneuvering my stiff, blue, ankle-length uniform over the muddy "off-wheel" of the livery stable buggy.

We all wore black high-top shoes; and what a stylish nuisance they were! I'll never forget the time we wasted buttoning them up. Sometimes on hospital night duty we were allowed to paddle around in carpet slippers. These may seem unprofessional to you modern nurses; but they were great time-savers and a comfort to us then.

Not the least of our problems was combatting society's reaction to our profession. Many good citizens of the Gay Nineties claimed they would rather die uncared for than be handled by a woman so bold as to go into hospitals and see "all that went on there." To many newspaper and magazine writers, we were only vulgar hussies who violated a man's bedchamber and exerted our power over him in his last illness. Cartoonists dubbed nursing the new road to matrimony and the "path to the altar by the new cult."

Only a few schools had adequate courses in those days. And they were able to produce only small groups of first-rate nurses.

Then, as now, we had trouble with the unprofessional. Public sentiment strongly favored those "natural born nurses" who helped to deliver babies and sat up with the sick as a matter of neighborhood habit. It was the family doctor who gave the *trained* nurse her start. He realized that in serious illness his orders must be carried out by a qualified person of his own choosing.

If there had been more registered nurses at that time, we might have forced the unqualified worker out of the picture entirely. But, unfortunately, the family doctor who wanted a registered nurse could not always locate one. There were only 16 graduate and student nurses per 100,000 population in the United States in 1900. So you can see how we had to spread ourselves around. And why the "born nurse" stayed on the job.

It was nothing to be called 100 miles on a case. Often to reach a patient I'd take a train to a village 80 miles distant. And you could bet your bottom dollar that this kind of call would be a third week typhoid or inflammation of the bowels. The bleakness of midnight would hang like a shroud 'round the railroad station. In the utter blackness, I would have to find the local livery and hire a horse and buggy for the 10-mile jaunt, out past the old mill, to the house with the lamp in the window.

Even then we had relatives to cope with. The kind that gathered half a dozen strong whenever a member of the family took to his bed. I recall one case where I had to sleep for several nights on top of the grand piano, bundled in a lone quilt, just because all the beds were occupied by kinfolks.

They had a bad habit, too, of peek-

ing through the keyhole into the sickroom to see if grandpa was changing his will in my favor. Many's the Cousin Agatha I've surprised on her knees outside the patient's door.

Such tiny things loomed large on the horizon when a nurse was on duty in the home. (With few exceptions all cases *were* nursed in the home.) Endless little controversies were forever arising. Should the nurse eat breakfast opposite the master of the house, with his wife lying sick abed? Or should she take her porridge in solitary state after he had left for "business?" Should the nurse wear a cap or not wear a cap? Should she be expected to darn the socks and corset covers? What about hanging sickroom equipment on the bathroom rack sacred to the boss's bath towels?

Our training somehow did not teach us to meet such problems. The then-required one year course was all too short to cover even the merest essentials. As a result, we tried to make up in practical technique and commonsense what we felt we lacked in scientific knowledge. We learned to follow doctors' orders and to see a case through to the best of our ability.

In contrast to the present student's 8-hour day, all our classes came after a full day's duty in the hospital. At night we had to sleep in the hall between the wards in case a patient wanted us. Sometimes, in the morning, while on duty in the operating room, we would faint from fatigue. After such an episode, our families would try to get us to leave training. But few of us ever gave in; and I for one have never regretted sticking it out.

One thing we old-timers *could* do (on a moment's notice) was to make an ordinary living-room ready for an emergency operation. This, notwithstanding the red and green Aubusson rug, heavy plush chairs, marble-top tables, family portraits, and all the knick-knacks of the Victorian period.

Somehow boiled water was ready and waiting in a tight-capped milk can. Bichloride solution was sprayed around. Cotton and gauze were sterile, even though the cook was peevish because "that creature" was baking her rags when bread was ready for the oven! Kerosene lamps were on hand if it was a night job.

Frequently we were called on to take our place at the head of a recumbent patient on the kitchen table and to administer the anesthetic with a folded newspaper or a water glass as the ether funnel. The readying-up and subsequent post-operative grind followed in due order.

We could sterilize horses' tail-hairs and roll them ready for dermal sutures. We could draft the lid of a cigar box for a wrist splint, or an umbrella for a leg fracture. We knew that ears of corn pulled piping hot from the wash-boiler and tucked into mama's black cotton stockings made excellent hot body packs.

So much of our weary work then has no place in the present scheme of things: climbing in and out of buggys, trotting down muddy clay banks to empty bed pans, improvising operating tables, bed racks, and such. These trifles were all-important long ago. On them, lives often depended when the nurse was on duty several miles from the nearest doctor and hospital supplies. Today the drug store is handy, the telephone convenient, the hospital the base of almost all serious nursing.

What's more, we saw 24-hour serv-

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"My Girl Friday—"

The office nurse is the doctor's right-hand man! Herewith is some practical advice on how to create a career for yourself in this field.

BY ELIZABETH RAND, R.N.

Black Star

"Miss Jenkins is My Girl Friday," said the doctor proudly. "I couldn't run my office without her."

Two years ago this same physician argued that no doctor needed a registered nurse in his office. To Miss Jenkins' credit, and to the credit of hundreds of nurses like her, is the fact that more and more doctors today demand professional nurses for their offices. They are beginning to realize that a presentable hostess is not enough.

Here, then, is a career opportunity with a real future for nurses who have appropriate personal and technical qualifications.

What is required of the nurse in an office?

She must be receptionist, clerk, telephone operator, and bookkeeper, as well as an efficient nurse. Sometimes she must function as laboratory technician; sometimes, as a social worker. Perhaps no other phase of nursing offers so many contrasts, so many chances to put the various facets of your nursing preparation to work.

There are no set rules for the evolu-

tion of an office nurse. A good general education and all-around nursing preparation, however, offer the best basis. Each physician, each surgeon or specialist has different needs and will expect his nurse to perform different duties.

Some doctors require their nurses to do all their secretarial work—shorthand, typing, bookkeeping, and filing—as well as attend to the professional duties. Others may employ a secretary as well as a nurse; these may expect the nurse to be a technician able to do X-rays, electrocardiograms, metabolisms, or diathermy treatments. Physicians who write a great deal need a nurse who can do the research necessary in the preparation of scientific papers. In other offices, she embodies a combination of all these things.

Not many of the nursing procedures you learn in the hospital will be used in a doctor's office. However, most doctors do some treatments in their offices which require skillful help and sterile procedure. You, as the assisting nurse, must be able to prepare for these treatments, to help with them, and to know what reactions to expect and what measures to take in case of emergency.

Although a college education is essential in some branches of the profession, it is not so important for the office nurse. You will find you can use your spare time and resources to greater advantage on outside cultural interests. The broader your interests and your viewpoint, the better your chances for success in an office. You will find that these interests help you to meet people graciously and to add friendliness and charm to the atmosphere of the doctor's office.

What are the special qualities that will make you an asset to your physician?

Most important is adaptability to surroundings, to varying duties, and to personalities. You must be willing to do any job which turns up in the course of the day, and to do it pleasantly. You should also have the instincts of a hostess receiving guests in her home.

Knowledge of typing, shorthand, and bookkeeping is valuable. Often the doctor will not require shorthand, but it is useful equipment anyway. Frequently there are long reports or complaints to be taken down and referred to the doctor, and it is very difficult to get them accurately in longhand. *Expert* stenographic knowledge is not a "must" requirement. But if you can arrange to take a short business course you will find it helpful.

A good telephone voice and manner are essential. So much depends on the impression a patient receives when phoning the doctor. To some extent the nurse can increase or decrease the doctor's practice by the way in which she handles telephone calls.

Patients are extremely critical of the appearance of an office nurse. Hence, you should be the kind of person who is immaculately groomed at all times. Aside from the uniform itself, your hair, hands, and shoes should receive constant attention.

If you believe you have the necessary qualifications for office nursing, look around and see where the immediate opportunities for employment may lie. The most direct approach to a job is through your hospital associates. Many doctors choose nurses with whom they have worked or who have been recommended to them by other

[*Continued on page* 38]

Nutrition Briefs

Because of its bearing on untold future generations, diet during pregnancy is perhaps our greatest single nutritional problem. Obstetricians have not been slow to accept the challenge, as is attested by the mounting emphasis placed on adequate diet during the prenatal period.

Pregnancy is characterized by an increase in basal metabolism of about 23 per cent over normal. To compensate for this increase, authorities agree that the gravid woman need consume only those foodstuffs which she ordinarily eats in the non-pregnant state—but she must eat *more* of them. For example, everyone needs about one gram of calcium daily; but the requirement during pregnancy is 1.4 gm. Extra vitamin D, of course, should be taken to help utilize the needed calcium.

Continued study of the calcium-vitamin D requirements of pregnancy discloses that an ample intake of these two factors will shorten the duration of labor. In a series of primiparæ given viosterol during pregnancy, labor lasted about 6 hours, whereas in a second group not receiving extra vitamin D, labor lasted 19 hours. Incidentally, worry is a factor influencing calcium metabolism. If a pregnant woman suffers anxiety, she is apt to excrete more calcium than she takes in.—*McCollum, E. V.: The Diet of the Pregnant Woman. Am. J. Obs. & Gyn. 36:586, Oct. 1938.*

Give a dog a diet that is lopsided in a special way, and it will promptly develop "black tongue," the canine counterpart of human pellagra. Throughout the South, impoverished families try to live on precisely the same lopsided diet; annually, pellagra takes its toll.

Only recently ("Nutrition Briefs," June 1938), hope rose for these unfortunate pellagrins with the discovery that nicotinic acid would cure black tongue in dogs. What of its effect in pellagra? After months of intensive research comes definite, irrefutable proof that pellagra results, at least in part, from a deficiency of nicotinic acid or of some closely related substance.

The administration of nicotinic acid to a pellagrin provokes a dramatic response. Within 24 hours, the tongue and mucous membranes become normal; nausea, vomiting, and diarrhea are checked; appetite returns; and acute mental symptoms vanish.

Promising though the outlook may be, nicotinic acid cannot replace all the essential components that are missing from the diet that predisposes to pellagra. For example, the correlated peripheral neuritis can be relieved only by adequate vitamin B_1 therapy. Pellagra, apparently, is a disease due to *multiple* deficiency, and it is best treated by a full diet with nicotinic acid and vitamin B_1.—*Spies, T. D., Grant, J. M., Stone, R. E., and McLester, J. B.: Recent Observations on the Treatment of Six Hundred Pellagrins with Special Emphasis on the Use of Nicotinic Acid in Prophylaxis. So. Med. Jour. 31:1231, December 1938.*

"Deeds, not words"

—AN EDITORIAL

• What has happened to the 8-hour day?

For lo, these many months we have been hearing the obvious: The profession believes that nurses caring for the acutely ill "should not be expected" to work more than 8 hours in 24. But we have not heard what the profession intends doing to provide an 8-hour day for *every nurse.*

Since 1933, when the campaign began, 969 institutions have adopted the shorter day for private nurses; half as many have it in effect for staff nurses.

In terms of the 6,137 hospitals approved by the Council on Medical Education and Hospitals of the A. M. A., these figures suggest that general staff nurses in 93% of these hospitals and private duty nurses in 85% of hospitals do *not* share the benefits of the 8-hour day.

In terms of grim resignation, dulled spirits, and tired bodies, the figures suggest an appalling number of nurses.

When will nursing shed its traditional timidity and stand more firmly on its convictions? Suppose hospitals *do* say the 8-hour day is impossible under present budgets. This rebuff need not halt effort. Surely some budgets

can be revised to include appropriations for nurses' well-being as well as for new equipment. Surely some economies can be made in hospital administration to throw fresh funds toward the nursing service.

But hospitals cannot be expected to take this initiative themselves. Nurses must point the way. It is not enough to pronounce the advantages of 8-hour duty to doctors and nurses. It is not enough to "educate" the public. It is not enough to stand by quietly and hope.

Under sound nationwide management, a workable plan should be devised as a basis of cooperation between local nursing groups and local hospital associations. Besides analyzing conditions, this plan should establish the means for concerted action throughout the country. It should provide the machinery for making 8-hour nursing a practical investment for each hospital.

Too much time has been spent in fact-finding; too little in putting the facts to work. The profession has been guilty of three dangerous evasions: "This needs careful thinking." "We must educate the community." "We must go slowly." Now it is time to stop rationalizing, to face reality. If the first concern of the nurse is her patient's welfare, then she cannot afford to ignore conditions which hamper her capacity to nurse safely. Nursing must insist that the drive for the 8-hour day be given greater impetus than it has in the past.

We have no wish to minimize the strides already made. But we believe patience has been over-stressed. Action likewise is a virtue.

Quick facts about

Syphilis

A CONCISE REVIEW OF CURRENT THERAPY AND NURSING CARE

• Prior to recognition of its causative organism (1905), and the discovery of effective therapy by Ehrlich in 1910, syphilis was probably the most dreaded disease. Today it is understood in great detail; and effective preventive and therapeutic measures are available for its control and eventual eradication.

The incidence of syphilis is estimated to be 8 percent of the white population and 20 percent of the negro population of the United States.

Causative organism.—The causative organism of syphilis is a spirochete, *Treponema pallidum*, discovered by Schaudinn. Long, narrow, and spiral shaped, it resembles a corkscrew. In the living state, it is highly motile, moving by rotating on its long axis. It is not a hardy organism, being readily killed by soap and water, by mild antiseptics, or exposure to air. It is stained with difficulty, and is grown only by means of special cultural methods.

Mode of transmission.—The most common method of transmission is through sexual contact. Although syphilis is usually regarded as a venereal disease, extravenereal transmission through kissing is not uncommon. Also, physicians and nurses have acquired the disease through accidental contact with open syphilitic lesions.

Since syphilis is so highly infectious, every nurse should be aware of the danger of infection. Any patient may be a potential source. Every open sore, especially on the genitalia, and all disseminated skin lesions, should be viewed with suspicion. Should accidental contact be made, the exposed surfaces should be washed with soap and water immediately, and then covered with an

ointment containing 50 per cent calomel.

Syphilis is transmitted extragenitally only through open lesions—the original chancre, and the skin lesions and mucous patches of the secondary stage. A patient with tabes dorsalis or visceral syphilis is usually not infectious, although the blood may contain spirochetes. Hence the rigid practice of taking Wassermann tests prior to transfusions.

There is some evidence to indicate that under certain conditions syphilis in the male may be transmitted to the sex partner by the semen. This sometimes results in the infection of the developing fetus. Children so infected are victims of congenital syphilis, a deforming and crippling type of the disease highly resistant to therapy.

Indirect transmission through contact with drinking glasses (or similar equipment) has been reported and must be kept in mind, especially in hospital ward service.

The chancre.—At the point of contact with the spirochete of syphilis, the primary sore or chancre develops within 10 to 40 days after exposure. Painless, indolent, and at times undiscovered, the chancre is an open sore one-half to one inch in diameter. Its base is hard, about the consistency of cartilage; the edges are circumscribed; the crater is beefy red and at times covered with a grey-yellow membrane. About 10 per cent of all primary lesions are multiple. In contrast to the typical picture, the chancre may be no more than a papule that refuses to heal or a persistent crack (especially on the lip).

The fluid expressed from a chancre teems with spirochetes and is highly infectious. The organisms are readily detectable by dark-field examination, a procedure advantageously employed in the diagnosis of early syphilis.

Some authorities now believe that the spirochete can invade the apparently unbroken skin. An older school of thought held that entrance could be gained only through an abrasion or other cutaneous defect. In either case, the nurse must guard against contact with the discharged fluid of the chancre.

Chancres are located most frequently on the genitalia. However, they have been found also on the lips, palate, tongue, tonsils, breasts, lower abdomen, upper thigh, and eyelid. In nurses and doctors, they may appear on the fingers.

In diagnosing syphilis, serum from the chancre is first collected in a capillary tube. Then it is sent to the laboratory for a dark-field examination.

The secondary stage.—If no treatment is instituted, the chancre heals spontaneously in about 5 weeks with the formation of a pigmented, light brown scar. The spirochetes, disseminated throughout the body, set up a generalized reaction. In about 6 weeks, the so-called secondary stage of the disease ensues.

The patient becomes listless, experiences headache and general malaise. He runs a low grade temperature and

Photos by Krutch, U. S. Public Health Serv.

This dark-field microscope finds the small, pale spirochete. The procedure is said to reveal syphilis ten to twenty days before the blood test shows a positive result.

may complain of mild cardiac and intestinal symptoms. A persistent sore throat and hoarseness, together with generalized lymphadenopathy, add to his discomfort.

The most spectacular feature of the secondary stage is the characteristic skin eruption. Appearing all over the body and protean in character, the rash can simulate any skin disease. It may be macular, papular, or pustular; in negroes, it may follow a typical pattern.

The outstanding lesions of secondary syphilis are the condylomata and mucous patches. The former, in reality papules, are hard wart-like masses, most frequently situated about the vulva and anus. The mucous patches are small, flat, grey lesions that are slightly raised above the surface. These may appear in the mouth, on the lips and tonsils, in the vagina, and on the prepuce.

The surfaces of both types of lesions contain large numbers of spirochetes and are therefore highly infectious. Mucous patches, perhaps most persistent of all luetic lesions, recur frequently after spontaneous healing. The open lesions of the secondary stage are as infectious as the chancre; in fact, transmission of the disease occurs most frequently during this stage.

Like those of the primary stage, the manifestations of the secondary stage disappear spontaneously after a variable period. With healing of the open lesions, the patient is no longer infectious except through transmission by semen.

The tertiary stage.—After subsidence of the secondary stage, the untreated or inadequately treated syphilitic infection becomes latent; no clinical manifestations are apparent. The patient, perhaps not having consulted a physician, assumes that he is cured of his unrecognized malady, and fails to seek professional advice until too late.

Many patients in whom latent syphilis is discovered deny knowledge of their affliction. In women, a chancre of the vagina or cervix produces no local symptoms and may go unnoticed. Sometimes, secondary lesions do not appear at all; hence it is understandable that patients may not be aware of their infection until it is revealed during an examination.

During the latent period, the spirochetes localize in various organs and tissues of the body and produce the typical lesion of the tertiary stage—the gumma.

The gumma is a hard nodular mass of rubber-like consistency. Not all organs are attacked in each patient. The reason for this variance in tertiary manifestations from patient to patient is not known. No organ or tissue (nor even the bones) is immune from the destructive syphilitic process of the third stage. In one patient the heart and blood vessels may be the site of the process. In another the liver may contain many gummas. Syphilitic involvement of the testicles is characteristic of the tertiary stage, and gives rise to the presence of spirochetes in the semen.

Syphilis of the brain and spinal cord is now classified as a manifestation of "late lues," occurring most frequently in untreated cases many years after the primary lesion. General paresis and tabes dorsalis represent the spirochete's active invasion of the central nervous system.

General paresis, or "softening of the brain," is an interesting organic psychiatric condition characterized by delusions of grandeur, grandiose ideas, irresponsibility, and impaired intelligence. In its earlier stages, paresis may not be easily detectable, and many innocent persons may become victims of the paretic's megalomania. Progressive deterioration of the mind finally makes the condition apparent. Paretics eventually find their way into institutions for the insane. Some recover to a variable degree as a result of therapy with tryparsamide and hyperpyrexia, while others succumb.

Tabes dorsalis produces specific degeneration of a portion of the spinal cord, resulting in impaired locomotion, attacks of excruciating pain (especially in the legs), and bladder paralysis. The walk of the tabetic is characteristic; unable to ascertain the exact position of his feet, he shuffles along with a slapping gait. In the advanced stages, conscious control of the bladder is lost. The organ is permitted to fill to capacity, and overflows, causing troublesome dribbling and necessitating periodic catheterization.

The pain of tabes, said to be the most intense man is forced to endure, is due to involvement of the spinal nerve ganglia. It may become so severe as to be resistant even to the action of morphine. The "gastric crisis" of tabes is a prolonged attack of pain referred to the abdomen. Nausea and vomiting complicate the picture, and have led to mistaken diagnoses resulting in unnecessary surgery.

The clinical picture of general paresis

[*Continued on page* 46]

★ ***This is the seventh of a series of articles on frequently encountered diseases. Inquiries from readers will be answered promptly by the medical and nursing members of*** **R.N.'s** ***staff who prepared the material.***

Uniforms, 1939

FIG. 2

What's new in uniforms? Here are a few highlights on the models which will be featured this spring.

• Time was when the word "uniform" meant literally "dress of a particular style or fashion worn by persons in the same service. . ." (apologies to Webster). But that regimented similarity is *passé* today, at least so far as concerns nurses' uniforms. New styles and new features galore are being offered by canny manufacturers who realize that nurses want to be chic as well as professional.

Here is a quick preview of the most interesting models to be shown this spring. All of these have some special advantages; all are priced between $3 and $4.

FIG. 1

Perhaps the most important development in uniform design this year is the successful adaptation of the "princesse" silhouette. Skeptics believed this an impossible feat —uniform fabrics were too unyielding, they said. Uniform craftsmen, however, selected their fabrics carefully. In sturdy but soft materials, they molded the accented shoulders, slim waist, and flared skirt of the princesse mode. The results lend new charm to on-duty apparel.

Getting the proper fit is no problem this season. Most of the styles now come in junior miss as well as in the misses' and women's sizes. The "in-between type" should be able to find, at last, a uniform she "doesn't have to do a thing to."

Notice in Figure 1 how the shoulders are emphasized by a yoke. The gores in the skirt give a graceful flare that allows for plenty of action. Width in the lower part of the skirt affords a clever way of making your waist seem neat and small by contrast. Figure 2 is another version of the new silhouette. This model is especially well-fitted at the waist and hipline.

Part of this slim look in the new uniforms is due to ingenious tucking. Tucks from collar to hem are seen on many of the best models, emphasizing a longer line and preventing bulges. Often they are used as out-and-out trimming.

Corded tucking is a design experiment that should be particularly successful. Notice how effectively it is used in Figure 5. Basically, this uniform is just a well-tailored garment. But the addition of close, corded tucks on either side of the concealed zipper lends individuality and really "makes" the uniform. (Fig. 5, page 31)

On the model shown in Figure 4, the tucks serve a double purpose. They trim the uniform and create a slim line as well. The sloping tucks in Figure 3 add unusual treatment to the bodice. These are "dressy" in appearance and create a slender, graceful line from throat to waist.

Some tucks are used to hide a very important detail, the zipper. These useful fasteners are still news for nurses because they are becoming increasingly popular for on-duty apparel. They now run the full length of many models, making it easier than ever before to change quickly. Some go diagonally from the collar to the belt to give added smoothness to the bodice. They have been improved now so that they almost never stick or break. However, if you launder your own uniforms, remember to close the zipper before putting the garment in water. This precaution prevents damage to the zipper and keeps the cloth from puckering.

FIG. 3

Necklines in the spring uniforms are varied. High, stand-up collars may not be news —but youthful ones are. In Figure 4, the tab on one side of the collar slides through an opening to button on the opposite side. The result is a neat collar that is still not severe.

A repetition of this interesting effect in the belt lends a unique finishing touch.

FIG. 4

Another collar (not illustrated) features rounded ends that button together in front. If your face is round, you are not at your best in a choker collar. But if you like its dignity, one designer has created a style which you may find easier to wear. This tapers into a slight "V" at the neckline and extends the line of your face.

The perennial open "V" gets the spotlight again this year. Figure 1, the button-to-the-neck collar, opens at the throat to form a boyish notched collar with lapels. Almost all the collars have longer points, which should be a relief to nurses with pleasingly plump faces. (Yes, you can still have the Peter Pan type, but current styling avoids it.)

Remember that people see you coming—and going. So don't consider the front of the uniform to the exclusion of the back. First of all, look for plenty of room. No matter how becoming a uniform is, don't buy it unless it allows for free arm action

FIG. 5

without pull. Fortunately, almost all styles are correctly tailored to meet the demands of active nursing. Backs with inverted pleats are good for all sizes because the pleat gives just that much more room for movement.

Next, consider your figure. If you have narrow, sloping shoulders, buy a uniform with a straight line yoke to make the shoulder line seem square. If, however, you think your shoulders are too broad, by all means hunt for a uniform with a pointed yoke back. The more you want to break the broad look, the deeper the point should be.

To nip in the waistline (to all appearances) find a back without a yoke but with diagonal tucks converging at the waistline. A few uniforms have a cunning button-up-the-back style. Unless you are young and girlish, however, avoid it.

Here is a new idea for the nurse who likes a loose belt on her uniform. One manufacturer secures the belt to the garment with a simple little loop, so simple that someone should have thought of it before. The belt can't disappear in the laundry, yet it lies flat to permit perfect ironing. (This same belt adjusts to the waistline.)

Fabrics, this year, have been chosen first for their durability; then for their manageable qualities and their ability to drape smoothly and stay crisp. One group of uniforms comes in a poplin with an interwoven cross design. This material is used in making nurses' uniforms *only*. (For nurses who like something *different*.) Another group of poplins has been improved and subjected to tensile tests by the American Institute of Laundering. These uniforms are now labeled with its approval.

Uniforms no longer keep to a year-in year-out style. Like street clothes, they are redesigned every season. And they are constantly being redesigned to keep step with current fashion trends (as well as with the efficiency of the modern nurse). So when you select your new uniforms, remember you can purchase smartness as well as service!

—SUSAN CARTER

(If you wish additional information about the uniforms mentioned in this article, please include with your request a self-addressed, stamped envelope.—THE EDITORS.)

Do you need a physician (general practitioner or specialist) in your community? If so, the magazine *Medical Economics* will be glad to help you. In a special department, it now lists the names of towns currently in need of doctors, thus calling these towns to the attention of the 125,000 physicians who receive the magazine each month. *Medical Economics* is a business journal for medical men. The address: Rutherford, N.J.

Calling all nurses

Is there someone in the profession you'd like to get in touch with? Already, this department has brought together scores of old friends! If you've lost track of a classmate, or want to find a co-worker from early nursing days, address a notice to the "Calling all nurses" editor. Each notice should not be longer than 100 words. You may sign your message with initials or a nickname, if you wish. But be sure to send along your full name and address so that replies may be forwarded to you. There is no charge for this service to registered nurses.

"WIMPY" NELSON: What has happened to you? Please write to me. Remember our night O. B. and all the food that I could find—somehow and somewhere? (I would appreciate any information about Miss Nelson, whose home was formerly in Georgia. She is a graduate of a hospital in Jacksonville, Fla., and was affiliated with the Indiana University Training School at Indianapolis.) Yvonne Buck, Atterbein, Ind.

LILLIAN SASNOFF: I should like to hear from anyone who knows about Miss Sasnoff. She trained at the New England Hospital for Women and Children. The last I heard, she was working at one of the medical centers in New York City. Mary F. J. LaCava, 238 Waldo St., Providence, R. I.

BERTIE LEE REYNOLDS: Does anybody have information about Miss Reynolds? I know she was in Birmingham in 1926, but I haven't heard from her since. She is a graduate of McCall Hospital, Rome, Ga., class of '22. Eva Bell Carues (Mrs. Joel Chapman), Shannon, Ga.

PEARL DEWEY: Remember the good old days at T.C.S.? I have lost all track of you and Hiatt. Please let me hear from you. Ella Grave Wilhite, 505 N. Sunset Blvd., Temple City, Calif.

SERVICE NURSES: I am a disabled ex-service nurse who served at Ellis Island, Otisville, and in Unit 71 of the A.E.F. My hobby is collecting the censored A.E.F. covers, envelopes, and cards. I hope that some ex-service nurses will help me add to my collection. Eva F. Gray, 166 Irving Ave., Providence, R. I.

VERA ABBOTT: Although it has been more than a year since we roomed together at Methodist, I've just discovered two medical dictionaries and one is yours. Let me know your address and I will send it. I would like to hear from any of my classmates. Where is everybody? Mary Anderson McClintic, 2323 E. Walnut Ave., Des Moines, Ia.

JEANNETTE BELLES: Miss Belles, graduate of Allegheny General Hospital, Pittsburgh, has been sought by her classmate, Beulah Finley Zeller, for several years. It is extremely important that she communicate with the husband of Beulah. Mrs. Zeller is critically ill and calling for her. Anyone knowing the address, please write Mr. M. A. Zeller, 5002 Lansdowne Ave., St. Louis, Mo.

MABEL ENGLAND: Does anyone know where Miss England may be located? She is a graduate of Silver Cross Hospital, Joliet. She did postgraduate work at the Chicago Lying-in Hospital in 1923. I know that she married since then. Margaret A. Shaw, 402 Whitney Ave., Joliet, Ill.

KAHLER GRADUATES: Will the graduates of Kahler Hospitals, Rochester (Minn.), class of '25-'26 who remember "Heinie" write to me? I would like to correspond with some of my classmates. Doris Hindal, 5530 Cornell Ave., Chicago, Ill.

Horse and buggy nurse

[*Continued from page* 18]

ice. Sometimes our patients would allow us to skip out for a walk in the evening with our "best," or to attend the church basket social. But other less-considerate patients thought they owned all our time, and made work in those odd moments when we might have relaxed for a spell. Theoretically, of course, we were supposed to have two hours off, if and when the patient needed us least. Sometimes, between tasks, we actually did get in a few good licks on the embroidered doily we were finishing for our hope-chest.

Every case was an adventure. Few people ever called a nurse unless the patient was dying and the doctor insisted. There was no such thing as a registry. We just "up and went" whenever the doctor called us for a case of double pneumonia, delirium tremens, typhoid, profound toxemia, gall bladder trouble, cystitis, tuberculosis, kidney upset, heart complication, carcinoma, apoplexy, smallpox, or childbirth.

Once in the dead of winter, I was called on an O.B. by the local doctor. It was 30° below zero, and the ground was thickly padded with snow. We started out in a sleigh at 3:30 in the morning, bundled in fur robes. Ahead of us was a 14-mile ride. Before we had traveled very far the snow started up again in new fury. The road was only a narrow path, and in the blinding storm we lost our way. Cutting across a field, our horse stumbled and broke his leg. Doctor and I continued on foot. The only light, our goal, was over a mile distant. Fighting wind and snow, we finally reached the house on foot, half frozen and exhausted. But

Analytical Studies of Solutions of Alka-Seltzer

This is the 11th in a series of exhaustive determinations to confirm the value of Alka-Seltzer as an aid to the quick relief of certain minor, everyday symptoms for which medical attention is not usually sought or needed.

In previous experiments it has been shown that the analgesic in Alka-Seltzer is presented in the form of an acetylsalicylate (Exp. No. 1); that Alka-Seltzer exerts a local antacid effect in the stomach (Exp. No. 2); that it provides a systemic alkalizing action after absorption (Exp. No. 3); that it tends to hasten gastric emptying time in cases of persistent gastric hyperacidity (Exp. No. 4); that it helps to relieve gastric hyperacidity following alcohol consumption (Exp. No. 5); that it is more rapidly evacuated from the stomach than plain aspirin (Exp. No. 6); that it dialyzes more rapidly than aspirin suspensions (Exp. No. 7); that single doses of from 10 to 20 grains of acetylsalicylic acid as aspirin or Alka-Seltzer exert no demonstrable untoward effect on the heart (Exp. No. 8); that Alka-Seltzer reduces the acidity of the urine (Exp. No. 9).

RESEARCH PROBLEM NO. 11

To determine by analytical studies: (1) The relative proportions of both salicylic acid and acetylsalicylic acid as either free acids or as salts bound with sodium in solutions of Alka-Seltzer tablets. (2) To make comparative analyses of solutions of mixtures of sodium bicarbonate and acetylsalicylic acid.

Experimental Method. Lack of space precludes a detailed description of analytical procedures which, however, included (1) Method for Determination of Free Salicylic Acid, (2) Method for Determination of Bound Salicylic Acid, (3) Method for Determination of Free Acetylsalicylic Acid, (4) Method for Determination of Total Acetylsalicylic Acid, (5) Method for Determination of pH.

Results. Analytical data are presented for free and bound salicylic acid and for free and total acetylsalicylic acid in solutions of Alka-Seltzer tablets in distilled water standing at room temperature for from 1 to 3 hours after effervescence has ceased.

Data presented in this report indicate that the sodium acetylsalicylate in an aqueous solution of Alka-Seltzer remains stable for more than 3 hours; it does not decompose with formation of either free acetylsalicylic acid or salicylic acid.

Analytical data for aqueous solutions of Alka-Seltzer presented in this report confirm findings of earlier analytical studies described in previous reports. Results of all analytical studies made to date indicate that solutions of Alka-Seltzer in water after effervescence has ceased contain all of the acetylsalicylic acid bound with base. Since this and previous series of analyses have revealed no free acetylsalicylic acid and since neither salicylic nor significant amounts of free salicylic acid have been found in experiments reported herein, it is evident that the acetylsalicylate in the solution of Alka-Seltzer does not undergo hydrolysis, i.e. it remains stable during standing at room temperature for at least 3 hours.

By contrast an aqueous solution of sodium acetylsalicylate prepared by adding to water a mixture of sodium bicarbonate and acetylsalicylic acid in proportion to their combining weights contained free acetylsalicylic and bound salicylic acid and the concentration of free acetylsalicylic acid was increased on standing for 3 hours.

An Alka-Seltzer tablet dissolved in a glass of water makes a sparkling, effervescent solution which helps to give relief from "sour stomach" brought on by indiscretions in eating and drinking and helps to relieve such minor symptoms as headache and discomfort accompanying the early stages of a cold.

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No. 12 of a Series

that was only the beginning.

In the two-room shack we found three children lying ill with every symptom of diphtheria. In the kitchen, the mother was waiting to be delivered. The only solution seemed to be to load the mother on a bobsled and take her to the neighbors'. Of course, it wasn't wise; but it was the sort of chance we had to take. Can you imagine the nightmare of the days that followed? I'm rather proud that only one death resulted.

Another time, on a hot mid-August day, after a gruelling trip to the distant countryside, I found two patients, instead of the expected one, ill with typhoid. An open bedpan lay behind the kitchen stove. On the kitchen table lay butter and cream from a long-past meal; over everything were flies. There wasn't a screen in the entire house, nor a hand solution. I was afraid to eat anything but fresh fruit and boiled coffee. Before the case ended I almost starved to death. One night, after a long struggle to keep the delirious father in bed, all was quiet for a heavenly moment. Thankfully, I was smoothing the sheets when a mouse ran across my hand. My self-control left me and I screamed. The patient opened his eyes, and out of his sickly gaze, saw my expression and the mouse. He began to laugh. I spent the rest of the night holding his stomach to quiet his hysterical giggling.

We didn't nurse for profit in those days. Our pay was whatever the family could afford. I've often taken my salary in board, plain sewing, and laundry work. In later years we did have our salaries set at $25 a week, $30 if an hourly sponge case.

But there were other greater compensations. We had the thrill of matching

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our ingenuity and knowledge against the almost insurmountable odds of weather, roads, and strange and serious illness. We learned to know our patients, their problems, their way of living. If the going was hard, our reward was twice as great when patients "slated to die" recovered through our efforts. And, we had the joy of pioneering a job and the pride of helping to raise the standard of a humanitarian profession.

If I could go back, I'd do it all over again!

"My Girl Friday—"

[*Continued from page* 20]

doctors. Investigate the needs of the doctors you know; perhaps they have offices where there might be a place for you.

Hospital registries and professional nursing bureaus have many calls for office nurses, so don't overlook this possibility in your search for employment. Then, too, with a little ingenuity you may be able to create a place for yourself. You can readily locate a few specialists whose work you understand. Approach them and see if they can make use of your services.

The salary of the office nurse depends to a large extent on herself. If she is willing to work to acquire knowledge which will make her more valuable to the doctor, her salary will be increased accordingly. A recent nationwide survey set $1200 a year as the median wage for office nurses. However, 40% of those included reported salaries between $1000 and $1600; 5½% ranged between $1600 and $1800; and 10½% had incomes over $1800. [*Turn the page*]

Prophylaxis and Treatment of Infections of the Upper Respiratory Tract

HEXYLRESORCINOL 'SOLUTION S.T. 37' should be employed in the nasopharynx full strength as a topical application or in dilution as a spray.

As an antiseptic irrigating solution, a dilution of one part Hexylresorcinol 'Solution S.T. 37' with two to four parts warm water is suggested. For localized infections, apply full strength.

For prolonged action, a saturated tampon or cotton pledget, where its application is feasible, may be employed as a wet dressing, using a dilution of two to four parts of warm water.

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While these figures are not exceedingly high, they do represent a steady, secure income. A conscientious, hard-working nurse with an eye to the future should find it easy to provide for her later years by saving carefully during her productive years.

Hours of duty vary greatly, depending on the nature of the physician's practice, and upon the number of persons employed in the office. For the most part, the 8-hour day is in effect, with an hour off for luncheon. Sundays are free, and usually one afternoon a week. Thanksgiving, Christmas, New Year's, and July Fourth are holidays.

Vacations depend on the individual doctor and office. The average length is three weeks or a month; in rare instances, six weeks or two months.

Here is how one nurse started her career in a doctor's office:

A well-known internist found it necessary to make a change in his office. Thinking over the various nurses he knew, he decided to offer the position to one whom he taught during her training period. She had been head nurse on a medical ward and also operating room supervisor. Before entering the hospital, she had had some schooling in shorthand and typing but had been out of practice for several years. This and her hospital experience were her only assets when she began her new work.

The first several months she had her hands full familiarizing herself with the patients, organizing the routine of the office, and going out with the doctor to assist with transfusions. On the advice of the doctor and with his help, she began to learn something of the laboratory work involved in the physician's practice.

Later she worked in a hospital labo-

ratory and learned to do blood chemistries. Then she went to summer school and took a course in clinical pathology.

At the beginning of her second year she had a small but well-equipped laboratory which she had installed in the doctor's office. Already her work had widened beyond its original scope.

Gradually this nurse was trained to do metabolism tests and diathermy treatments. Then, as the quarters began to be too small and cramped, the office was moved to larger space where an electrocardiograph, fluoroscope, and X-ray equipment were installed. Now the nurse has been instructed in the operation of these valuable aids to the practitioner of internal medicine. She has created a real career for herself by making her services indispensable.

Each type of work, of course, has its own compensations. The financial rewards of office nursing are far exceeded by the other satisfactions of the work. In the office you work *with* the doctor, not *under* him; you are his trained and valuable assistant.

Then, too, there is the pleasant advantage of meeting people of all types and ages—the chance to broaden your understanding of people. Only those who have been in close contact with a good doctor in the trying times of critical illness can realize under what strain he labors and how much an efficient, sympathetic helper can mean to him.

Office nursing requires tact, diplomacy, and quick thinking. If you have these in addition to technical preparation, perhaps there is a future for you in this field. Put it down on your list of "things to look into in 1939" if you are contemplating a change in your nursing status. It is a job with responsibility not found in the more routine branches of the profession.

The convalescent must often abstain from the usual foods and physical activity which help stimulate peristalsis.

In such cases, Saráka aids in toning and strengthening the intestinal musculature which has become flabby from inactivity. Bland, easily-gliding, lubricating ***bulk*** (provided by bassorin) mixes intimately with the feces—softening and smoothing them. Frangula, subjected to a special process, is incorporated in an amount sufficient to induce adequate ***motility*** by its gentle tonic action. This combination of

BULK PLUS MOTILITY

makes Saráka a definite aid in regulating bowel habit. The well-formed stool moves naturally, without griping, digestive disturbances, or annoying leakage.

Saráka is not habit-forming and may be used safely for young and old, and during pregnancy and lactation.

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Nurses talk too much

[*Continued from page* 12]

sons try deliberately to embezzle medical advice without paying for it. Little minds seek to bolster their own inferiority by making capital of errors in others. Both types bait nurses for their opinions on different cases. It's a temptation not to show off our professional knowledge and to express ourselves freely. But if our opinion turns out to be wrong, it won't help *us* or our profession.

Even if the facts are on your side, it isn't good sportsmanship to spotlight mistakes.

An opinion on a case about which you know the facts only by hearsay is sheer folly.

You may always change the subject to avoid making comment. My memory lingers pleasantly over a nurse member of a bridge club. The players were upset about a friend whose appendix ruptured prior to operation. They queried the nurse as to the danger of such a condition. "Sometimes it is dangerous, and sometimes it isn't," she replied and changed the subject. Complained a listener, "Ruth never tells you anything." That is a real tribute to Ruth.

Words once spoken can never be recalled. For your own sake and for the sake of the profession, be a nurse who "won't talk" either in or out of case!

See you in jail!

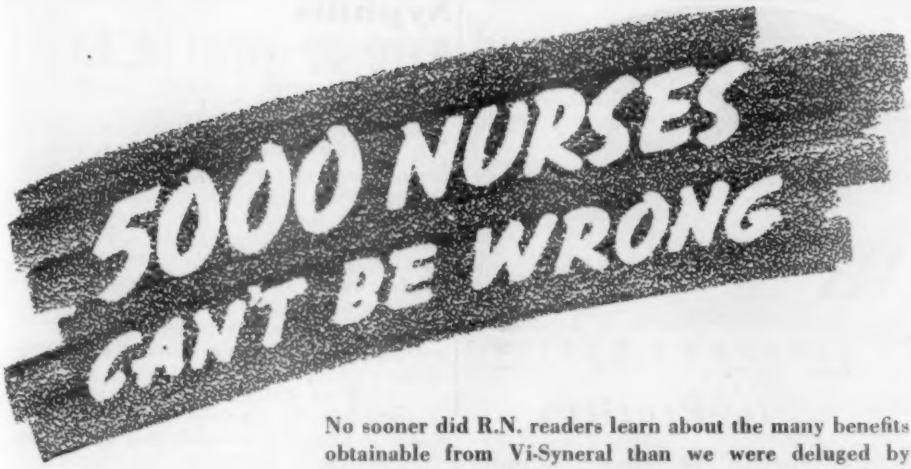
[*Continued from page* 15]

"'Well, sew 'er up,' he chuckled, 'and I'll see her tomorrow.'

"So I patched her up and administered drugs from the miniature pharmacy, while the ghost of malpractice whooshed around me. I spent a busy night running from mother to daughter and back again. I thought of concussion, fracture, infection, tetanus, and several dozen other things during the long hours. When the sun rose after a thousand years I was thin and worn and pale. But—dear, darling little Rosemary bounded off her pillow and raced down to the cook for breakfast before I could lay a hand on her.

"So you can believe me when I say that I went through fire. And this time the enamel of common sense is permanently baked on! Come on, now—do you think I'm right or wrong?"

"I'm no Solomon," I hedged. "Let your conscience be your guide, or words to that effect. In the meantime, how about a chocolate soda to sweeten your disposition?"



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Syphilis

[*Continued from page 27*]

and tabes dorsalis is usually accompanied by abnormal spinal fluid findings which, if present, are diagnostic. It is well known that the best results from modern therapy are obtained in the early stages of syphilis of the central nervous system. Abnormal findings in the spinal fluid practically always precede the development of clinical manifestations. If proper treatment is given before clinical symptoms develop, good results can be obtained in a great many cases. For this reason every patient with syphilis is urged to submit to a spinal fluid examination.

Syphilis of the central nervous system characteristically produces the Argyll Robertson pupil, a valuable diagnostic sign. This pupil fails to react to light, but reacts to accommodation. At times the pupils may be unequal and asymmetric.

The Wassermann test.—Announced in 1906 by the man whose name it bears, the Wassermann test is probably the greatest single stride that has been made toward the control of syphilis. Properly performed, it accurately determines the presence of syphilis, active or latent.

The Wassermann reaction becomes positive about two months after the infection is acquired, and usually remains so until the process is eradicated. The intensity of the reaction is recorded roughly by the "plus method"—a four plus (+ + + +) reaction strongly demonstrating the presence of syphilis. However, in syphilis of the central nervous system, the blood Wassermann may be negative, though the spinal fluid gives a strongly positive reaction. A one plus (+) result is a questionable finding, and demands repetition.

Opinion is divided as to whether a diagnosis can be made solely on the basis of a positive Wassermann reaction. Most authorities agree that other signs must be present, or a suggestive history presented, especially since other conditions occasionally give rise to a positive reaction.

The term "Wassermann fast" is applied to patients who show a persistently positive reaction even after prolonged treatment. It is believed by some syphilologists that this finding indicates the presence of a hidden, active, syphilitic focus.

In recent years, other tests for syphilis have been devised, the most common being the Kahn and Kline tests. Most physicians prefer the Wassermann and regard the other two as valuable for check or corroboration.

In drawing blood for the Wassermann

test, strict aseptic technique is followed. It is important that both the syringe and bottle into which the blood is placed be absolutely dry, since the presence of moisture may lead to erroneous results. The bottle should be sterilized previously, although this is not essential if the blood is kept in a refrigerator and the test performed shortly after the blood specimen is obtained.

Treatment.—In the opinion of all authorities, syphilis can be cured, providing adequate therapy is given early enough and for a sufficient length of time. We owe our most potent weapon, salvarsan, to Ehrlich who in 1910 synthesized this effective arsenical.

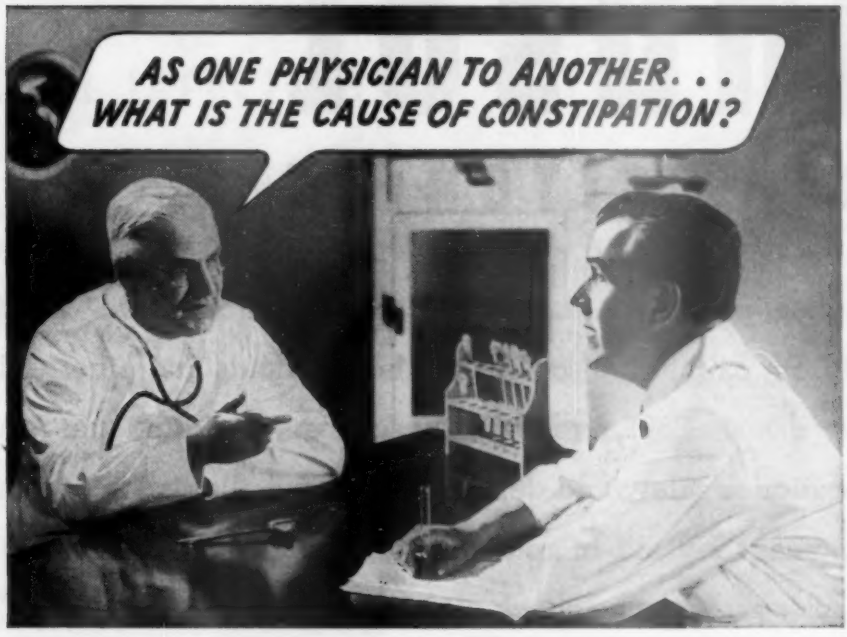
In the United States, syphilis is treated with alternating courses of neoarsphenamine and bismuth, with no rest periods between courses. A minimum of about 18 months of therapy is required in the average case.

Treatment is begun immediately after the diagnosis is made. It is well established that the earlier the therapy is instituted, the better the prospect for a complete cure. If treatment is begun while the chancre is still present, before the Wassermann reaction becomes positive, and is properly continued, a complete and permanent cure is virtually assured.

The administration of arsenicals and bismuth immediately halts the progress of the disease. If given during the primary stage, treatment leads to disappearance of spirochetes from the chancre in 48 hours, and to healing in a very few days. A similar rapid response is seen during the secondary stage. When treatment is delayed, however, the chances for ultimate success become fewer.

It must be emphasized that every pregnant woman should be given the Wassermann test as soon as pregnancy is recognized. Syphilis in the expectant mother almost invariably produces congenital syphilis in the newborn. However, if antisyphilitic treatment is started during the first trimester and continued until term, a normal, nonsyphilitic child will be delivered. Through this simple procedure congenital syphilis will eventually be eradicated.

The recent change in public attitude, the recognition of syphilis as another infectious disease which may be discussed openly, and the eradicative measures instituted by federal, state, and local authorities, will unquestionably reduce the incidence of syphilis and lead eventually to its complete control. In the educational program which brings syphilis into the limelight and establishes it as a *curable* disease, every nurse plays an important part.



OBVIOUSLY, there is no single cause. Each case must be judged on its own merits. Anatomical differences, variations in diet and habit and specific pathological entities all enter into the cause. However, it is safe to say that faulty habit plays a role in the great majority of cases, and that loss of neuro-muscular tone is a very common secondary factor.

To make habit training easier, a bland, pure mineral oil is important. To increase tonus of debilitated intestinal musculature and nervous system caused by Vitamin B-1 deficiency, pure crystalline Vitamin B-1 has been found to be of great value.

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Vita Nujol is a smooth, pleasant-tasting emulsion of pure mineral oil with pure crystalline Vitamin B-1 added in such quantity that the suggested average dosage is the average adult maintenance dose of that important food factor (400 International Units).

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WHITENER: How much time do you spend cleaning white shoes? You probably want to answer, "Half of my life." Yet SHINOLA may reduce this waste. It cleans and whitens in a jiffy, and is said to remove stubborn stains collected in the operating room. Its makers insist that it won't rub off either! Send for your sample to Hecker Products Co., Dept. RN 1-39, 88 Lexington Ave., New York, N.Y.

CATHETERS: Hospitals are forced to spend much unnecessary money in replacing catheters that have cracked or otherwise lost their serviceability. Perhaps *you* can help reduce expenses by learning the best way to clean and sterilize them. To master the art, send for a leaflet explaining the proper care and maintenance of catheters. American Cystoscope Co., Dept. RN 1-39, 1241 Lafayette Ave., Bronx, N.Y.

ITCHING, even without lesions, may be a dangerous source of infection. But there is relief for pruritus sufferers in CALMITOL. Applied directly to the involved area, it is said to render the patient comfortable for prolonged periods and to prevent secondary infection from scratching. Calmitol comes in liquid and ointment form and is reported to be helpful in controlling eczema, food and drug rashes, ivy and oak poisoning, and ringworm. Registered nurses may write for a sample. Thos. Leeming & Co., Dept. RN 1-39, 101 W. 31st St., New York, N. Y.

OIL: Baby rashes merely annoy baby; they drive mothers, especially brand new ones, frantic. A top-to-toe daily rub with MENNEN antiseptic oil may help keep the delicate infant skin free from these rashes. Mennen also has a borated powder which augments the antiseptic efficiency of the oil. Nurses may obtain free professional samples of both by writing the Mennen Company, Dept. RN 1-39, Newark, N.J.

APRON: Here is a uniform protector for "splashy" tasks. Made of satiny white latex, PLAYPRON has no stitches or seams to collect dust. All edges are reinforced for durability. It is waterproof, yet can be boiled or autoclaved. The neckline stretches generously. Thus you may don the apron—or take it off—without upsetting your cap. A detachable pocket comes with it, in white or colors. For a picture and a swatch of material, write to International Latex Corp., Dept. RN 1-39, 350 Fifth Ave., New York, N.Y.

UNCTION: Winter is a painful season for those affected with chronic rheumatism or neuralgia. Pain, swelling, and stiffness are aggravated by nippy weather. Local application of IMADYL UNCTION (containing histamine) should provide warmth and relief to sufferers. Winter sports lovers may find it a balm for overexercised muscles. To obtain a professional sample tube, address Hoffmann-LaRoche, Inc., Dept. RN 1-39, Roche Park, Nutley, N.J.

ANTIPRURITIC: Patients are eternally grateful for any relief from pruritus. Nupercainal CIBA is said to act promptly, yet to continue to assuage pain and itching safely and effectively. Called the "local anesthetic" ointment, it is used by doctors for superficial burns, hemorrhoids, and varieties of dermatosis. Write for trial tube and literature. Ciba Pharmaceutical Products Co., Dept. RN 1-39, Summit, N.J.

Classified

This department is conducted as a service to R.N. *readers. To apply for a "position available," list your qualifications in a letter. Address it to* R.N.—A JOURNAL FOR NURSES, *Rutherford, N. J. Specify positions by individual box number. Do not send money with application. (The bureaus which require a registration fee will bill you after filing your application.) Submit "positions wanted" early. The first ones received each month will appear in the current issue.*

POSITIONS AVAILABLE

***ANESTHETIST:** California. Anesthetist and clinic nurse for 400-bed county hospital. Straight 8-hour duty. Good technique preferred to lengthy experience. Salary $140 and meals. W115.

***ANESTHETIST:** Kentucky. Willing to relieve floor duty, 60-bed general hospital. Salary $108 and maintenance. (Placement bureau charges $2 registration fee.) C703.

***ANESTHETIST:** Massachusetts. For 200-bed hospital; two other anesthetists on staff. Position may be permanent if applicant proves satisfactory after 6 months. Salary $100 and maintenance. E213.

***ANESTHETIST:** Minnesota. Anesthetist required by 60-bed hospital. Salary $135, maintenance included. D23.

***DIETITIAN:** Florida. Registered nurse qualified on special diets. Graduate staff, 50-bed general hospital. Salary $80, maintenance. (Placement bureau charges $2 registration fee.) C706.

***DIRECTOR OF NURSES:** Pennsylvania. For fully approved 90-bed general hospital; 25 students. Prefer applicant between 35 and 40 with degree and some experience. Salary $150 and maintenance. (Placement bureau charges $2 registration fee.) C707.

***GENERAL DUTY:** New York. Hospital in Westchester, 200 beds; 8-hour duty. Salary, day duty, $60 and maintenance; night duty, $65 and maintenance. E214.

***INSTRUCTOR:** Arizona. Practical instructor for 200-bed Catholic hospital. Salary $125, meals and laundry. W116.

***INSTRUCTOR:** Southern state. Science instructor for small hospital. Salary open. E215.

***INSTRUCTOR:** Wyoming. Nursing arts. Small training school; 75-bed hospital. Salary open. W117.

***OBSTETRICAL:** Connecticut. Postgraduate work in obstetrics and good experience necessary. Hospital (200 beds) has training school. Salary $100 and maintenance. E221.

OFFICE NURSE: New Jersey. Atlantic City physician requires office nurse experienced in physiotherapy, simple laboratory procedures. Send complete data first letter, including age, salary, experience, marital status, references. AM5.

***PHYSIOTHERAPIST:** New York. Physiotherapist registered in New York State needed for hospital in New York City. Salary $100. E216.

***RECORD LIBRARIAN:** Western state. Post open in 225-bed general hospital approved by the American College of Surgeons. Large city in Rocky Mountain region. Salary according to experience. (Placement bureau charges $2 registration fee.) C713.

***SUPERINTENDENT:** Virginia. Candidate must also combine duties with anesthesia or management of kitchen. Modern 35-bed general hospital. (Placement bureau charges $2 registration fee.) C715.

***SUPERINTENDENT OF NURSES:** New Jersey. Hospital has 200 beds, training school. Within reach of New York City. Age about 35 preferred. College work and good experience essential. Salary open. E218.

***SUPERINTENDENT OF NURSES:** Oregon. For private 75-bed general hospital; 30 students. Applicant should be capable of supervising entire nursing service and teaching operating room technique. Salary $125 and maintenance. (Placement bureau charges $2 registration fee.) C717.

***SUPERVISOR:** California. Pediatric. Teaching supervisor for 110-bed hospital offering 4-month postgraduate course. Salary $90-100. (Placement bureau charges $2 registration fee.) C711.

***SUPERVISOR:** California. Large county hospital seeks operating room supervisor. Graduate staff; new building and equipment. W118.

***SUPERVISOR:** North Dakota. Night post in 117-

**Asterisk indicates position listed by a placement bureau.*

bed general hospital with training school. Prefer experienced nurse interested in obstetrics. Salary open; maintenance included. (Placement bureau charges $2 registration fee.) C710.

***SUPERVISOR:** New Jersey. For operating room in 200-bed hospital with training school. Special preparation and experience necessary. Salary $125 and maintenance. E219.

***TECHNICIAN:** California. Well-known Hollywood physician requires graduate nurse with knowledge of laboratory or X-ray. W119.

TECHNICIAN: Nebraska. Large city weight control clinic desires services of nurse and technician. Quote qualifications, years of service, etc. in application. Address: Dr. Lee W. Edwards, Edwards Weight Control Clinic, Barker Bldg., Omaha, Neb.

***VISITING NURSE:** New York. Applicants living within 50-mile radius of New York City only will be considered. New York registration and public health experience essential. Candidate must be extremely expert driver. Salary $125; increase after 6 months. E220.

POSITIONS WANTED

ANESTHETIST: Familiar with Hiedbrink gas machine and drop ether. Willing to combine anesthesia with other duties. Fine experience, good references. Age 30; Protestant. Salary open. Box 1-1.

GENERAL DUTY: West Virginia registration. Experienced private and general duty. Minimum acceptable salary $75 with maintenance. Wishes Florida position only. References. Box 1-2.

GENERAL DUTY: Diversified experience includes pediatrics; medical, surgical, and communicable disease nursing. Especially interested in psychiatric work. Would consider part-time position. Health excellent. Box 1-3.

GENERAL DUTY: Age 27. Colored. Two years of college. Formerly in surgical nursing, obstetrics, night supervising, private duty. Able to administer anesthesia with ether only. Willing to locate anywhere. Box 1-4.

GENERAL DUTY: Pennsylvania registered nurse wishes general duty in a private or general hospital. Prefers Pennsylvania or Ohio. Minimum salary, including maintenance, $75. Age 22, 1937 graduate. Box 1-5.

INDUSTRIAL: In active duty 14 years as supervisor, emergency nurse, house director, and administrator. Also experienced private duty. Prefers position vicinity Philadelphia. Registered in Pennsylvania. Drives own car. Protestant. Box 1-6.

INDUSTRIAL: New York registered nurse desires post New York City or vicinity. Age 27. Previously in charge of medical and surgical ward; in relief charge of diagnostic clinic. Institutional and private duty experience; also some business training. Salary open. Box 1-7.

OPERATING ROOM: Alumna of large New York hospital; postgraduate work in operating room at Charity Hospital, New Orleans. Three years' experience operating room and general ward. Age 29. Protestant. Salary open. Also interested in general duty. Box 1-8.

RECORD LIBRARIAN: Employed record librarian and medical stenographer wishes to change position. West preferred. Six years' experience as librarian. Box 1-9.

SCHOOL NURSE: Registered in Georgia. Seeks position as school or industrial nurse. Three years' experience. Age 30. Protestant. Box 1-10.

SCRUB NURSE: Recent graduate of St. Elizabeth's Hospital, Chicago, desires work as a scrub nurse in operating room in Illinois or adjoining states. Would consider general duty. Protestant, Age 21. References. Box 1-11.

SUPERINTENDENT OF NURSES. Age 36. Extensive hospital experience. Registered in New York, California, and Washington. Prefers California or West Coast. Box 1-12.

SUPERVISOR: Seeks public health post. Postgraduate and 3 years' practical experience in public health, pediatrics, and communicable diseases. Pennsylvania registration. Box 1-13.

SUPERVISOR: For pediatric division or infant floor. Special training and experience in both. Prefers work in Connecticut where registered. Catholic. Age 38. Box 1-14.

SUPERVISOR: New York registered nurse, graduate of 110-bed hospital. Experienced 4 years as supervisor in tuberculosis ward specializing in chest surgery. Would like tuberculosis supervising position in California. Box 1-15.

SURGERY NURSE: Desires post in foreign country. Excellent references from major California hospitals. Age 30. Box 1-16.

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DOCTOR: "Yes, indeed, Mrs. Browning. You should experience no difficulty whatever in using Tampax..."

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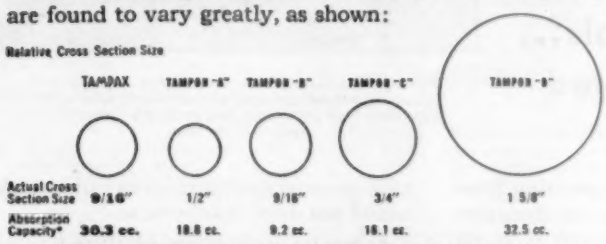

	TAMPAX	TAMPAX "A"	TAMPAX "B"	TAMPAX "C"	TAMPAX "D"
Actual Cross Section Size	9/16"	1/2"	9/16"	3/4"	1 5/8"
Absorption Capacity*	30.3 cc.	18.8 cc.	9.2 cc.	16.1 cc.	32.5 cc.

* The figures indicate volume of oxalated beef blood absorbed in five minutes.

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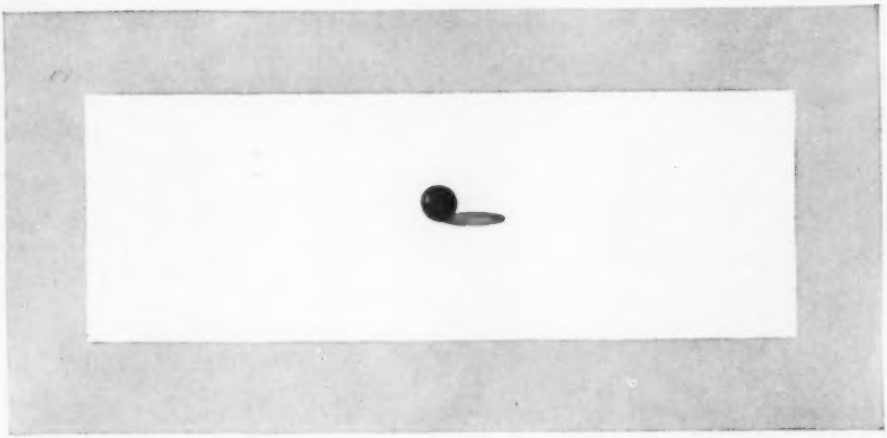

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